IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 30, 2008

Steve Silberberger
Seven Oaks Community Homes Silkwood
3940 West 5th Avenue #C
Post Falls, Idaho 83854

RE: Seven Oaks Community Homes Silkwood, Provider #13G025

Dear Mr. Silberberger:

This is to advise you of the findings of the Medicaid/Licensure survey of Seven Oaks Community Homes Silkwood, which was conducted on September 25, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **October 13, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by October 12, 2008. If a request for informal dispute resolution is received after October 12, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

SHERRI CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

SC/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G025	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS COMMUNITY HOMES - SILKWOOD	435 SILKWOOD POST FALLS, ID 83854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your recertification survey. The survey was conducted by: Sherri Case, LSW,QMRP	W 000		
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the comprehensive functional assessment included an assessment of vocational skills which specified each individual's work interests, work attitudes, work-related behaviors, and potential present and future employment options for 1 of 3 individuals (Individual #1) for whom such assessments were required. Without a comprehensive assessment, the facility would be unable to assist an individual with his vocational training needs through development of objectives designed to optimize his abilities. The findings include: Individual #1's IPP, dated 6/24/08, documented a 27 year old male diagnosed with severe mental retardation. He attended a vocational training program from 10:00 a.m. until 1:30 p.m. Monday through Friday. When asked if a vocational assessment had been completed, the QMRP stated, on 9/25/08 at 11:20 a.m., no. The facility failed to ensure Individual #1's comprehensive functional assessments included current, specific, and comprehensive information	W 225	**W255** It is the facilities intent to ensure that all functional assessment needed for each individual is obtained as appropriate. The facility also works to coordinate programming to address needs across both the home and vocational settings for all individuals. In this instance the identified person has been transitioning from a completely home based provision of services to beginning to participate in the vocational setting. A vocational assessment addressing additional skills beyond the continuation of home based program had not yet been completed. All other individuals being served have had vocational assessments completed and this person's assessment will be completed as well. Completion Date: 11-25-08 By Whom: Program Director and Vocational Services Supervisor	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Program Director — 10-23-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	13G025	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS COMMUNITY HOMES - SILKWOOD	435 SILKWOOD POST FALLS, ID 83854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 225	Continued From page 1 related to his work strengths and needs, work attitudes, and work-related behaviors.	W 225		

PRINTED: 09/26/2008
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEVEN OAKS COMMUNITY HOMES - SILKWO	435 SILKWOOD POST FALLS, ID 83854

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MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225.	MM724	**MM274** Please refer to W225	

Bureau of Facility Standards

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Director — (X6) DATE: 10-23-08

STATE FORM 6899 MBBD11 If continuation sheet 1 of 1